Aitch Care Homes (London) Limited

Woodbridge House

Inspection report

151 Sturdee Avenue
Gillingham
Kent
ME7 2HH
Tel: 01634 281890
Website: www.achuk.com

Date of inspection visit: 08 July 2014
Date of publication: 17/02/2015

Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

The inspection was unannounced. Woodbridge House is registered to provide residential care for a maximum of ten people who require varying levels of support to manage conditions such as learning disabilities, autism, down syndrome, physical disabilities and non-verbal communication disorders. The service is within close proximity to a bus route, local shops and amenities, which gave easy access to the community for people.

There was a registered manager at Woodbridge. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

The service was safe because people who used the service were protected from the risk of abuse, and the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. People we spoke with informed us that they felt very safe and had no concerns. One person said, “I feel very safe here with staff support” and a relative said, “I believe my relative is safe here because members of staff are good”.

Staff had the information they needed to provide personalised care and support. People’s health and care needs were assessed with them, and people were involved in writing their plans of care. People told us they were very happy with the way they were cared for. People’s needs were taken into account with the use of pictures and Makaton sign language to facilitate those with communication difficulties.

Staff had been trained in essential areas and staff told us they received opportunities to meet with their line manager to discuss their work and performance.

People's diversity, values and human rights were respected. The care plans had information about each person's initial assessment and important people in their lives. Staff cared for people in the way that was set out in their care plans. Support was given in a person centred way, and produced plans with people that included promoting their health, financial arrangements and setting goals

The service was responsive to people’s needs. Care records showed that people visited the home before they moved in and the service had received various records about the people’s assessed needs. They responded to changes in needs by liaising with professionals regarding additional support that might be needed.

We saw that people were made aware of the complaints system. This was provided in a format that met their needs and people had their comments and complaints listened to and acted upon without the fear that they would be discriminated against for making a complaint. Staff told us that they would assist people who used the service to complain if they wished. A member of staff said, “I listen to them and encourage them to raise concerns in residents’ meetings”.

There was an open and positive culture which focussed on people who used the service. The manager had an open door policy so that people who lived in the home, staff and visitors could speak with him at any time.

Staff said they felt well supported by the manager. One staff member said, "We receive a lot of support from the manager and it is helpful and encouraging".

The service worked well with other agencies and services to make sure people received their care in a joined up way. For example, the provider was a certificated gold member of British Institute of Learning Disabilities (BILD). The manager told us that being a member of BILD has enabled them to be up to date in their skills and knowledge of how to support, promote and improve people’s quality of life through raising standards of care and support in the home.

People were actively involved in developing the service in a variety of ways, such as residents’ meetings, satisfaction surveys, forums and day to day contact with the management team. Suggestions made by people were acted on. This meant that people’s views were taken into account.

Throughout our visit the staff and management team showed us that they were committed to providing a good service. There were effective systems in place to monitor and review the quality of the service. The management team carried out regular audits to make sure that any shortfalls were identified and improvements were made when needed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from abuse because staff knew what to do and who to contact if they had any concerns about people. All staff had been trained on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). People were supported to make decisions about their care and welfare and they were not able to do so, best interest meetings would arranged.

There were risk assessments in place regarding people's care. The home operates a risk management approach to keep people safe.

There were enough qualified, skilled and experienced staff to meet people's needs and staff were employed using a robust recruitment system.

Is the service effective?

Good

The service was effective.

People were supported by care staff who have the necessary skills and knowledge to meet their assessed needs, preferences and choices. Staff have effective support, induction, supervision, appraisal and training.

People were supported to be able to eat and drink sufficient amounts to meet their needs and people were provided with a choice of suitable and nutritious food and drink.

People were registered with the GP and there were records of regular contact with them and other professionals such as, dentists, chiropodists, psychiatrist, psychologist and with an ophthalmologist. People were supported by staff or relatives to attend all of their health appointments.

Is the service caring?

Good

The service was caring.

People's diversity, values and human rights were respected.

The practice at the home was caring, people's privacy and dignity were respected. People were positive about the care they received and this was supported by our observations.

Support was given in a person centred way, and produced plans with people that included promoting their health, financial arrangements and setting goals. Staff were knowledgeable about the needs of people who used the service and the ways in which individuals were supported.

Is the service responsive?

Good

The service was responsive.

People's care needs were assessed before they received a service. More information had been obtained about people after they moved into the home to make sure staff knew how to meet their needs.

Summary of findings

People receive the care and support they need in accordance with their valid consent and were encouraged and supported to take part in a variety of appropriate activities inside and outside the home.

People were made aware of the complaints system. This was provided in a format that met their needs. People had their comments and complaints listened to and acted upon without the fear that they would be discriminated against for making a complaint.

Is the service well-led?

Good

The service was well led.

People, staff and visitors experienced an open and positive culture which focussed on people who used the service.

The service worked well with other agencies and services to make sure people received their care in a joined up way and staff were aware of the organisation's vision and values.

There were systems in place to manage and report accidents and incidents. The home had a number of systems in place to make sure that the service assessed and monitored the quality of its delivery of care.

Woodbridge House

Detailed findings

Background to this inspection

We inspected on 08 July 2014. Our inspection team was made up of one inspector. We spoke with two people who lived in the home, one care staff, the assistant manager and registered manager. We also contacted health and social care professionals who provided health and social care services to people. These included community nurses, speech and language therapist, local authority care managers and commissioners of services.

At the time of our visit, there were ten people who lived in the service, some people required one to one staff support while others needed additional support to meet their needs. The people who lived at Woodbridge House had diverse and complex needs such as learning disabilities, autism, down syndrome, physical disabilities and non-verbal communication disorders. Two people out of ten were able to communicate with us, as a result of this, we observed care and support in communal areas and also looked at the kitchen and some people's bedrooms, as well as a range of records about people's care and how the home was managed.

Before the inspection, we gathered and reviewed information from notifications, which are information we received from the provider about their services. We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR was information given to us by the provider which asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This enabled us to ensure we were addressing potential areas of concern, and health professionals' such as local authority commissioning officer's comments about the service.

During our visit we looked at the provider's records. These included two people's personal records and care plans, two staff files and a sample of the home's audits, risk assessments, surveys, staff rotas, policies and procedures. We interviewed staff and the manager.

At our last inspection we found no concerns or breaches of regulation.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

People we spoke with informed us that they felt very safe and had no concerns. One person said, “I feel very safe here with staff support” and a relative said, “I believe my relative is safe here because members of staff are good”.

There was a safeguarding adult protection policy in place, which detailed what actions would be taken by the provider to help keep vulnerable adults safe. This information was in a user friendly format that people were able to understand.

The provider had a whistle blowing policy, which stated that the provider encouraged people to raise concerns and that they would deal with concerns in an open and professional manner. We looked at the training records and found that all staff had been trained about whistle blowing.

Staff knew what to do and who to contact if they had any concerns about how people were being treated. One member of staff said, “I have completed safeguarding training and I am aware of the signs of abuse. We watch out for physical marks and mood changes, amongst other signs. If we are concerned, we refer this to our manager for further investigation. I can also refer to outside agencies like the local authority and Care Quality Commission if required”.

All staff had been trained on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). One member of staff said, “MCA and DoLS covers everyone. We must assume capacity, right to make decision and use of less restrictive way of working”. We found that if a person had capacity to make decisions, they had been involved in the planning and delivery of their care. If not, a family member had been involved in making decisions on their relative's behalf. The manager confirmed that the home made decisions by liaising with social workers, health professionals, relatives and advocates. The manager said, “For those who are unable to have direct contribution to decision making, decisions are made on their behalf by liaising with funding authorities, medical professionals and other significant people in the person’s life such as family members”. The manager recently made Deprivation of Liberty Safeguards (DOLs) applications to local authorities, showing that people’s rights we considered and the manager understood their responsibilities in relation to this. The manager had received granted authorisations from the local authorities regarding locked doors and some restricted access in the home.

There were enough qualified, skilled and experienced staff to meet people's needs. The permanent staff team comprised of support workers, senior support workers, the assistant manager and the registered manager. The manager told us that the staffing rotas were based on the individual needs of people who used the service. The home provided minimum cover of five members of staff on the day shift, four on late shifts and two night staff for ten people. During our inspection we saw that the five staff rostered on duty were on shift. We observed that additional staffing was organised to support individuals who required one to one support, those attending appointments, and supported people to engage and participate in chosen activities in the community. Staff confirmed that people always had one to one support for activities; such as trampolining and to keep them safe in the home and out in the community.

The home had a risk management approach that empowered people to take assessed risks and make decisions. Individual information forms had been produced on each person in case of an emergency. There were risk assessments regarding people’s care. These covered for example people’s poor mobility, smoking, incontinence, epilepsy, diabetes, challenging behaviour and risk to people’s skin integrity. The risk management to minimise these were documented in the care plan and gave guidance to staff. Care plans and risk assessments were internally reviewed and an external care plan review meeting was held with the person's social worker, relatives and other professionals at regular intervals and when required.

Systems were in place to make sure that the manager and staff team learnt from events such as accidents and incidents. This reduced the risk of harm to people and helped the service to continually improve. We reviewed accident and incident records and saw that these were correctly completed by staff, and were assessed by the manager. Monthly audits were carried out so that any trends could be quickly identified and dealt with accordingly.

People were protected by a robust recruitment system. We saw from two staff files that the recruitment procedures

Good

Is the service safe?

included checks for applicants' identity including a recent photograph; two written references; a full employment history with any gaps in employment discussed; and Disclosure and Barring System (DBS) checks. Applicants were asked to show proof of any previous training. Interviews were carried out and an interview record was retained. Successful applicants were required to complete a detailed induction programme and probationary period over 6 months. We saw that written assessments were included as part of the training programme, and were discussed with the manager or deputy to ensure that the new staff member understood their training and were competent in the area of work concerned.

Good

Is the service effective?

Our findings

People told us that their health needs were known by the staff and were effectively met. For example, one person said, "If I am not well they take me to see the doctor. They took me for a filling at a dentist immediately after I told them I was unwell. They explained the process to me and I agreed to see the dentist".

People were registered with the GP and there were records of regular contact with them and other professionals such as, dentists, chiropodists, psychiatrist, psychologist and with an ophthalmologist. People were supported by staff or relatives to attend all of their health appointments. They were enabled to attend these via the home's minibus. Some people became frustrated at times due to their inability to communicate verbally, but we saw that staff had insight into their different communication methods and were able to gain an understanding of what they wished to say. People had been referred to other health professionals such as speech and language therapists to explore different methods to aid communication. Outcomes of people's visits to health professionals were clearly recorded in the care plans. Other health care professionals involved in people's care and support included the psychologist, district nurses, occupational therapists and a physiotherapist. These health professionals visited people in the home on a regular basis. Monitoring charts were completed for meeting different health needs such as dietary needs, continence care, personal hygiene and weight records.

We spoke with professionals who were involved in the provision of healthcare at the home and were informed that people were supported to maintain good health. One healthcare professional commented, "The manager is amazing. He does what you ask quickly. He ensures programmes are carried out and that the right things happen. People are safe and outside support is called in when needed".

People were supported to be able to eat and drink sufficient amounts to meet their needs and people were provided with a choice of suitable and nutritious food and drink. Care records contained information about their food likes and dislikes and there were helpful information on the kitchen notice board about the importance of good nutrition, source and function of essential minerals for both staff and people to refer to. There was a picture based food menu available to people. Guidance for staff was provided in the form of a bad and good food for diabetes chart in place because one person was diabetic, and a daily five portion of vegetables guide. One person told us that they were offered a choice of menu for breakfast, lunch and tea. This included a choice of vegetables and hot and cold drinks. We observed lunch and saw that staff offered people different types of food and enabled people to choose before being served. The lunch period was calm and people joked and enjoyed their food with staff support. One person said, "The kitchen was always open and I can have a snack at any time, including night times and I like it that way".

Staff files included completed application forms, education and work histories. A staff induction programme was in place. This included shadowing an experienced worker until the care worker was deemed competent. We saw that files contained evidence of a relevant qualifications. Staff had achieved a national vocational qualification level 3 (NVQ) in health and social care.

We requested for the staff training plan to be sent to us after the inspection. The plan showed that all staff had been trained in areas such as autism, moving and handling, first aid, emergency aid, food hygiene, safeguarding, MCA, DOLS, infection control, epilepsy awareness and medication administration, which showed that they had the necessary skills and knowledge to meet people's assessed needs. One member of staff gave an example of how they will handle a safeguarding issue and said, "Safeguarding is to keep people safe in all areas particularly those vulnerable to abuse. If there is an allegation of abuse, I will make sure the person is made safe, report it to my line manager, I will support the person by reassuring the person. I can also report to CQC and local authority care manager as external bodies".

Staff told us they met with their line manager to discuss their work and performance. One member of staff said, "I had my supervisions with my line manager as well as my yearly appraisal". The manager confirmed this and said, "Supervisions are carried out at least every six weeks to make sure people receive the required support". We looked at two staff files which showed that annual appraisals were carried out in April 2014, which identified development & training needs. For example, moving and handling training

Good

Is the service effective?

was identified as required for a member of staff and this was immediately planned for by the manager. One healthcare professional said “Staff are well organised, informed, and proactive”.

Good

Is the service caring?

Our findings

People and the healthcare professionals we spoke with told us they were happy with the care and support received in the home. One person said, “I like living here, staff are nice”. A healthcare professional said, “This is a home I would recommend and would be happy for a relative to live in.”

There was evidence in the care plans that people's diversity, values and human rights were respected. For example, the home had food and fluid requirement and support forms completed which ensured that people’s nutritional diverse needs were met. This took account of the support needed, religious needs, allergies, behaviour around food and preferences in order to ensure that their religion, beliefs and values were respected and taken into consideration when preparing the menu. The care plans had information about each person's initial assessment and important people in their lives. Staff cared for people in the way that was set out in their care plans. The care records showed staff gained knowledge about people's likes and dislikes over a number of years. For example, a member of staff said, “We meet their needs by getting to know them, reading their care plans, knowing their likes and dislikes”. This meant that people were respected and their preferences were acted upon by staff.

We spent time in communal areas and saw that the interactions between people and staff were caring, respectful and there was an understanding from the staff of people’s individual needs and ways of communicating. Staff gave people time to express themselves. For example, staff sat down on the carpet with one person who choose was to sit on the carpet to do jigsaw puzzle.

Staff told us how they involved people in their care. A member of staff said, “We involve the people who use the service through making decisions on their preferred activities. We look at their choice of activity and how we could meet these while respecting their wishes”. Another staff said. “We involve the people who use the service through making decisions on their preferred activities. For example, like preparing meals or going out”. We saw evidence of involving people in the development of their communication needs. For example, people’s needs were taken into account with the use of pictures and Makaton sign language to facilitate those with communication difficulties.

Staff treated people with respect and maintained their privacy and dignity. They knocked on people’s doors before entering; or where people liked their doors to be left open, the staff knocked and called to them before entering the room. All the people we spoke with were very positive about the caring standards of the staff, and confirmed that they felt that they were treated with dignity and respect. One person said “The staff are very caring, they provide all the assistance I need”, adding “I don’t think there is anything they could do better”. The home provided suitable facilities to maintain people’s privacy and dignity and to meet their preferences. For example, a separate dining and sitting area for people who like their privacy, and bedrooms had en-suite bathrooms and shower rooms.

Support was given in a person centred way, and care plans were produced with people that included promoting their health, financial arrangements and setting goals. People who needed support going out into the community had support workers assigned specifically to assist them to achieve these goals. We observed this during our visit when a member of staff supported one person into the community for an activity on a one to one as stated in their support plan. Behavioural guidelines were in place to support staff with managing difficult behaviours. Training certificates were held to confirm that members of staff were trained and competent in identifying triggers such as noisy environment and recognising other early indicators of behaviours that challenge the home, so that non-physical interventions could be used to prevent a crisis from occurring. This enhanced people’s quality of life and give people the skills to communicate their own needs, rather than present with a behavioural challenge.

Staff were knowledgeable about how to support each person in ways that were right for them. Staff were knowledgeable about the needs of people who use the service and the ways in which individuals were supported. Staff told us, “People have different needs, so the support needs are different. We refer to their support plan in order to meet their needs” and “I read the care plans regularly to meet people’s needs. If there are any updates on people’s welfare, I will find it in the care plan. We discuss changes in service users’ needs in order to meet them”.

The staff told us how they supported people with limited communication to express their views and wishes. They told us they always ensured they included the person in decision making. Staff sought the views of professionals,

Good

Is the service caring?

relatives and advocates to make sure the person's needs had been fully considered. Staff told us they used their skills and knowledge of the person to understand the person's needs, for example, their facial gestures and body language. We saw during our inspection that staff spoke with people in a caring and sensitive manner, gave people choices and included them in discussions and decisions. For example, we saw staff offer one person a choice of cold or hot drink and the person made their choice.

Good

Is the service responsive?

Our findings

People and the healthcare professionals we spoke with told us that the home was responsive to people's needs. One person said, "I told staff that I wanted to go to Butlins for holiday last year and they responded by planning it with me. I chose who went with me and I loved it". A healthcare professional said, "Staff are proactive. I had trouble in the past with requests for such items like getting a wheelchair for someone but this has changed and the staff and manager get things sorted at once".

We looked at the care records of two people who live in the home. These showed that people visited the home before they moved in and the manager had received various records about the people's assessed needs. The manager told us, "We carry out a full initial assessment before anyone is admitted into the home. We then develop a care plan, risk assessment and behavioural guidelines for the person. We liaise with professionals regarding additional support that might be needed". More information had been obtained about people after they moved into the home. We saw records that had been completed of people's 'life history' and relationships. Assessments had been carried out, for example in relation to behaviours and behavioural guidelines developed. This information helped staff to get to know the person well and provide them with the right care and support.

People received the care and support they need in accordance with their valid consent. Records contained consent to care forms that were signed by the person or their representatives. People were asked for their permission before staff did anything. For example people were asked if they had finished or would like anymore before their plates were taken away at lunch time. We saw that staff and management knocked on people's doors, even when they were open, and waited for permission before they went into people's rooms.

We saw that people had furnishings and personal effects on display in their individual bedrooms, which reflected their personal choices. People's rooms were decorated according to their preferences. One person said, "I chose to redecorate my room the way I want".

People were encouraged and supported to take part in a variety of appropriate activities inside and outside the home. Each person had an individual weekly activity plan. Staff confirmed that people were supported to attend all their planned activity of interest unless they chose not to. Activities included drives out in the company vehicle, attending college and trampolining sessions. One person said, "I go to the college for computer lesson as I like computers. I attend College on Thursdays and I do art on Friday". Another person's activity based on their need was to have a drive out into the community as this had a calming effect on them when agitated.

People were made aware of the complaints system. This was provided in a format that met their needs and was also on display in the entrance hall of the home where it was easily accessible. People had their comments and complaints listened to and acted upon without the fear that they would be discriminated against for making a complaint. People said that staff were patient in listening to their views and responded well. They were confident that they could raise any concerns and that these would be addressed promptly and effectively. Each person had a copy of the complaints procedure attached to the inside of their care file.

Staff told us that people who did not use verbal communication would point to this if they had any concerns, so that the staff could work out with them what their concern was and how to deal with it. The complaint procedure included contact details for the company's senior management, and for other agencies such as the local Social Services. The manager told us that there had been no formal complaints made during the last year. There were systems in place to investigate complaints and to respond to them appropriately.

The staff we spoke with told us that they were aware of the complaints policy and procedure as well as the whistle blowing policy. Staff we spoke with knew what to do if someone approached them with a concern or complaint and had confidence that the manager would take any complaint seriously. A member of staff said, "I am aware of the complaints policy and procedure. I have read it. If I have any problems, I will go to the deputy manager first before going to the manager". This meant that the provider made sure that staff were aware of the complaint's procedure and encouraged them to raise concerns, if needed.

Staff told us that they would assist people who use the service to complain if they wished. A member of staff said, "I listen to them and encourage them to raise concerns in residents' meetings". Another member of staff said, "We

Good

Is the service responsive?

have a user friendly complaints procedure in pictorial format on notice boards, which explained the processes to the people. We encourage people to complain". This meant that staff understood the company's complaints procedure for people who use the service and supported them to raise concerns whenever required.

Good

Is the service well-led?

Our findings

Our observations and discussions with people, staff and visitors, showed us that there was an open and positive culture which focussed on people who use the service. The manager had an open door policy, and actively encouraged people to voice any concerns. Both staff and people were observed as they approached the manager in his office with few concerns, which were addressed immediately by the manager. Staff said they felt well supported by the manager. One staff member said, "We receive a lot of support from the manager and it is helpful and encouraging". One healthcare professional said, “As with all residential homes, it depends on the manager and the current one is amazing”.

When we asked the manager what they felt was ‘good’ about the service, they told us that they were proud of the progress that people made and their achievements based on their challenges. They said, “We make referrals to professionals if and when required”. This was supported by comments from a healthcare professional who said, “The manager does what you ask quickly. He ensures programmes are carried out and that the right things happen”.

The service worked well with other agencies and services to make sure people received their care in a joined up way. We found that the provider was a certificated gold member of British Institute of Learning Disabilities (BILD). This organisation stands for people with learning disabilities to be valued equally, participate fully in their communities and be treated with dignity and respect. The manager told us that being a member of BILD has enabled them to be up to date in their skills and knowledge of how to support, promote and improve people’s quality of life through raising standards of care and support in the home.

Staff were aware of the organisation’s vision and values. They told us that their role was to support people to be more independent, care for them and ensure they have a fulfilled life. The home had an inclusive culture where people were actively involved in developing the service in a variety of ways. For example, residents’ meetings were used to gather people’s views on all aspects of the service, with different topics on the agenda each month. We saw that people talked about the menus and what they would like to eat and if they liked it. They also discussed their preferred activities, which meant that people were included in decision making.

Records showed people were asked for their views about care and treatment in June 2014 and areas such as gender preference in delivering care, which was requested by a family was acted upon. We saw questionnaires to gain people’s views This was named “Quality assurance for friends and relatives; care managers and professionals; staff and service users. The result stated that people were generally happy with the service provided. Comments from families such were, “From my point of view, my relationship with the home is great” and from professionals, “No concerns identified” and “I have had some concerns regarding the level of support in the past. But feel that these issues are being addressed”.

The home had a registered manager in post who was supported by a deputy manager. People and their relatives knew the management team well, saw them often and told us they felt comfortable approaching them. Staff told us that their manager was approachable, valued their opinions and treated them with respect. The registered manager told us that openness and transparency was encouraged among staff and this was discussed in staff meetings to make sure staff were given the opportunity to raise any issue that may be of concern to them. For example, we saw that a variety of other areas were discussed, including the needs of the people, activities, health appointments, key worker responsibilities, menu planning and records. This showed that staff were given the opportunity to discuss issues in order to improve the service.

There were systems in place to manage and report accidents and incidents. Accident records were kept and audited monthly by the registered manager to look for trends. This enabled the staff to take immediate action to minimise or prevent accidents. These audits were shown to us as part of their quality assurance system. Staff made comments such as, “We document all incidents using the correct sheet, report it to the manager who will investigate and also report it to higher management if need be.”

The home had a number of systems in place to make sure that the service assessed and monitored the quality of its delivery of care. This included monthly audits of staff training, medication, health and safety, infection control;

Good

Is the service well-led?

and incidents and accidents. The manager told us that they carried out weekly walkthrough of the home and monthly observation of staff practice as part of his quality assurance system. The audits showed that although the service was meeting all standards at the time of our inspection, they still identified areas where they could do more to improve further. For example, the audit of all personnel files found that there was a need to ensure all staff have completed the Common Induction Standards. The registered manager had put an action plan in place which showed the timescale of achieving this.

The registered manager told us that regular spot checks were carried out by the senior management. There were various audits carried out such as a monthly regional operations manager audit, which was last carried out on 19 June 2014, an operational audit which looked at staffing, training, records, nutrition, environment, security and safety, drug administration and storage, care and social needs and care plans and manager's observation. This audit developed action plans for updating care records in the home, which was carried out by staff. Other action plans for example as a result of the audit was that all risk assessments were to be fully reviewed by June 2014, which had been completed by the time of our visit. The CEO visited the home on 28 April 2014 to meet and greet people and staff.